HMA HEALTHCARE MANAGEMENT ADMINISTRATORS

CITY OF RENTON

1055 South Grady Way Renton, WA 98057

►►► ***EMPLOYER TO COMPLETE SHADED SECTION***

Group Policy Numbers	**Employment Data**	**Type of Enrollment**	**Effective Date**	**Change Form For**	
HEALTHCARE MANAGEMENT ADMINISTRATORS	Date of Hire ____/___/____	☐ Open Enrollment	____/___/____	☐ Reprint Cards	☐ Add Dependent(s)
CITY OF RENTON #4034	Date of Rehire ____/___/____	☐ New Employee	____/___/____	☐ Name Change	☐ Drop Dependent(s)
	Effective Date ____/___/____	☐ Re-instatement	____/___/____	☐ Address Change	☐ Cancel Employee
		☐ Change in Status	____/___/____	Effective Date of Change:	____/___/____

LOCATION: ***check one***

☐ AFSCME ☐ Council/Mayor - Elected ☐ Firefighters 864 ☐ LEOFF I Active ☐ LEOFF I Retired

☐ Non-Union/Mgmt ☐ Police Guild – Uniformed ☐ Non-Uniform Police ☐ Non-Union/Clerical LOCATION:_____

►►► ***EMPLOYEE: PLEASE COMPLETE THIS INFORMATION ABOUT YOURSELF - PLEASE PRINT CLEARLY***

☐ ***I DECLINE ALL COVERAGE OFFERED TO ME (PRINT AND SIGN NAME ON BACK OF FORM)***

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED
HOME MAILING ADDRESS				HOME PHONE NUMBER	EMAIL ADDRESS	
CITY		STATE	ZIP	WORK PHONE NUMBER	JOB TITLE OR OCCUPATION	

COVERAGE/PARTICIPANT ELECTION FOR EMPLOYEE ☐ **MEDICAL/RX** ☐ **DENTAL/VISION** ☐ **ONLY** ☐

►►► ***EMPLOYEE: COMPLETE THIS INFORMATION FOR DEPENDENTS WHO WILL BE ENROLLED ON MEDICAL/ DENTAL BENEFITS & MAKE BENEFIT SELECTIONS***

ADD	DROP	CHECK ALL THAT APPLY	LAST NAME, FIRST NAME	SOCIAL SECURITY NUMBER (REQUIRED FIELD)	DATE OF BIRTH	GENDER	SELECT: MEDICAL/RX	SELECT: DENTAL/ VISION	SELECT: ONLY
☐	☐	☐ SP / DP *				☐ MALE ☐ FEMALE	☐	☐	☐
☐	☐	☐ CHILD				☐ MALE ☐ FEMALE	☐	☐	☐
☐	☐	☐ CHILD				☐ MALE ☐ FEMALE	☐	☐	☐
☐	☐	☐ CHILD				☐ MALE ☐ FEMALE	☐	☐	☐
☐	☐	☐ CHILD				☐ MALE ☐ FEMALE	☐	☐	☐

Are any of the dependent children listed above ELIGIBLE for coverage through their own employer's plan or through their spouse's employer's insurance plan? ☐ Yes ☐ No
If yes, please list the names of those dependents who are eligible for that coverage here: _____

* If enrolling a Domestic Partner you need to be registered as Domestic Partners with the State of Washington. Please submit a copy of your registration with the State.

►►► ***DISABLED DEPENDENT ELIGIBILITY***

List dependent who is developmentally disabled or physically handicapped and who is over age 25: _____
Medical documentation must be submitted within 31 days of the effective date of coverage

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►►► *EMPLOYEE: PLEASE COMPLETE THE FOLLOWING COORDINATION OF BENEFITS INFORMATION IF APPLICABLE*

Currently do you, your spouse or any of your children have coverage through another insurance plan? ☐ Yes ☐ No

If yes, please complete the following:

Marital Status: ☐ Single ☐ Married_____ ☐ Widowed ☐ Legally Separated ☐ Divorced
Name of Spouse/Domestic Partner

If divorced, is there a court order for provision of the child? ☐ Yes ☐ No If Yes, please attach a copy of the court decree.

Per court decree: Who has custody of child? _____ Who provides insurance for child? _____

Please list the full name of the child(ren) _____

Please list both the natural parents name and date of birth:

Natural Father _____ DOB _____ Natural Mother _____ DOB _____

List all family member(s), including yourself, who are included on this enrollment form and are currently covered through another plan.

Name of covered members:	Type of Coverage: (M)edical (D)ental (V)ision	Type of Policy: (G)roup (I)ndividual	Effective date of coverage:	Carrier Name:
_____	_____	_____	____/____/____	_____
_____	_____	_____	____/____/____	_____
_____	_____	_____	____/____/____	_____

Provide the following information on the carriers listed above:

Carrier Name: _____ Policy Number: _____

Street Address: _____ City: _____ State _____ Zip _____

Carrier phone #: _____ Subscriber's Name: _____ Social Security Number: _____

Date of birth: _____ Employer's Name and Address (if group coverage) _____

Is Employee, Spouse/Domestic Partner covered under this medical plan eligible for Medicare benefits? ☐Yes ☐ No

If Yes, enter Date of Eligibility for Medicare Part A _____ Date of Eligibility for Medicare Part B _____Social Security No._____

►►► *RELEASE AND AUTHORIZATION*

I certify that the above listed information is correct and that I am enrolling only eligible dependents as defined in the Plan Document. *By signing this form, I attest that all dependent children listed for coverage are under age 26 and are not eligible for coverage through their own or their spouse's employer.* I understand that all entitlements to benefits are void, and coverage may be canceled or modified retroactively to its effective date, if I have made intentionally false or misleading statements or answers on behalf of myself or any family members. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to Healthcare Management Administrators or its designated agent. I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. * Health information requested or disclosed may be related to treatment or services performed by: 1) A physician, dentist, pharmacist or other physical or behavioral health care practitioner; 2) A clinic, hospital, long term care or other medical facility; 3) Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or 4) An insurance carrier or group health plan. Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Privacy Notice. A copy is available upon request.

PRINT EMPLOYEE NAME _____ **►►► SIGNATURE**_____ **DATE**_____